TITLE 85
EXEMPT LEGISLATIVE RULE
WORKERS' COMPENSATION RULES OF THE
WEST VIRGINIA INSURANCE COMMISSIONER

SERIES 1
CLAIMS MANAGEMENT AND ADMINISTRATION

§85-1-1. General.

1.1. Scope. -- This exempt legislative rule establishes the requirements and procedures to be followed by the Insurance Commissioner, private carriers, self-insured employers, third-party administrators, claimants, health care providers, vocational professionals, and others involved in the administration of claims.

1.2. Authority. -- W. Va. Code §§23-2C-22; 33-2-10(b); and 33-2-21(a). Pursuant to W. Va. Code §§23-2C-5(c)(2) and 33-2-10(b), workers' compensation rules proposed by the Insurance Commissioner and approved by the Industrial Council are not subject to legislative approval as would otherwise be required under W. Va. Code §29A-3-1 et seq. Public notice requirements of that chapter and article, however, must be followed.

1.3. Filing Date. -- July 18, 2008.

1.4. Effective Date. -- August 17, 2008.

§85-1-2. Definitions.

As used in this exempt legislative rule, the following terms have the stated meanings unless the context of a specific use clearly indicates another meaning is intended.

2.1. "Acted upon" means, but is not limited to, any one of the following: 1) received and processed; 2) contacted a claimant, employer, or medical provider in any fashion requesting more information; 3) reviewed and examined by medical personnel; 4) conducted a potential overpayment analysis; 5) cross-checked with other state agencies for relevant information; and 6) and other similar administrative steps which must be taken before a request can be ruled upon.

2.2. "Board of Review" means the workers' compensation board of review created pursuant to W. Va. Code §23-5-1 et seq.

2.3. "Decision" means any determination by a responsible party regarding the compensability of a claim, the award or denial of any type of benefit in a claim, or any other substantive request by a claimant in a claim.

2.4. "File" means:

a. If mailed, the date on which document being postmarked;

b. If faxed, the date on which fax is sent;

c. If emailed, the date on which email is sent to the email address for the recipient; and

d. If hand delivered, the date on which the document is delivered.

2.5. "Employer" means an employer within the meaning of W. Va. Code §23-2-1, et seq.

2.6. "Injury" and derivative words have the meaning ascribed to the term "injury" by W. Va. Code §23-4-1.

2.7. "Commissioner" means the Insurance Commissioner of West Virginia or any designated third-party administrator of the Insurance Commissioner.

2.8. "Office of Judges" means the workers' compensation office of administrative law judges pursuant to W. Va. Code §23-5-1 et seq.

2.9. "Paid" means the time a check is deposited in the mail or presented in person to the claimant, claimant's attorney or anyone acting in his or her behalf.

2.10. "Private carrier" means an insurer authorized by the Insurance Commissioner to provide workers' compensation insurance pursuant to chapters twenty-three and thirty-three of the West Virginia Code and any third-party administrator designated by the private carrier to adjust West Virginia workers' compensation claims.

2.11. "Receipt" means:

a. If mailed or hand delivered, the date on which the document is delivered into the possession of the responsible party;

b. If emailed, the date on which the document is received in the email inbox of the responsible party; or

c. If faxed, the date on which the document is received in the fax machine of the responsible party.

2.12. "Responsible party" means the Insurance Commissioner, private carrier or self-insured employer, whichever is applicable.

2.13. "Self-insured employer" means an employer who is eligible and has been granted self-insured status pursuant to the provisions of W. Va. Code §23-2-9 and the rules promulgated thereunder, and any third-party administrator designated by the self-insured employer to adjust West Virginia workers' compensation claims.

2.14. "West Virginia workers' compensation coverage" means workers' compensation coverage which provides the employees of an insured employer workers' compensation benefits consistent with chapter twenty-three of the West Virginia Code and the rules promulgated thereunder.

§85-1-3. Claimant's Report of Injury and Application for Compensation.

3.1. General.

Immediately after sustaining an occupational injury, a claimant should 1) seek necessary medical care; 2) immediately on the occurrence of the injury or as soon as practicable thereafter give or cause to be given to the employer or any of the employer's agents a written notice of the occurrence of the injury; and 3) file a workers' compensation claim or request that one be filed on his or her behalf. Failure to immediately give notice to the employer of the injury weighs against a finding of compensability in the weighing of the evidence mandated by W. Va. Code §23-4-1g and dilutes the credibility and reliability of the claim. Notice provided to the employer within two (2) working days of the injury shall be deemed immediate notice: *Provided*, That under no circumstances shall the fact that notice of an occupational injury was provided by the claimant later than two (2) working days from the time of the injury be the sole basis for denial of a claim. Enforcement of an employer's personnel policy requiring that a claimant report an injury immediately is not a discriminatory practice under chapter twenty-three of the West Virginia Code.

3.2. Benefit rate calculation; wage information.

It is the joint responsibility of the claimant and the employer to ensure that the correct wage information is provided to the Insurance Commissioner or private carrier so that the correct benefit rate can be paid the claimant. If the responsible party receives inaccurate wage information, the responsible party will, upon receipt of accurate wage information, adjust prospectively the benefit rate. The submission of inaccurate wage information by the employer or the receipt of benefits based on inaccurate wage information by the claimant may serve as evidence of abuse or fraud under the applicable provisions of the West Virginia Code.

§85-1-4. Employer's Report of Injuries.

The claimant's employer shall report to the private carrier every injury sustained by any person in its employ within five (5) days of the employer's receipt of the notice of an employee's desire to file a claim.

§85-1-5. Special Rules for Temporary Total Disability Claims.

5.1. To qualify for temporary total disability benefits, the claimant must have missed more than three (3) consecutive days of work due to the compensable injury before benefits become payable. To receive temporary total disability benefits for the first three (3) days of work, the claimant must have missed more than seven (7) days due to the compensable injury.

5.2. If an individual retires, as long as the individual remains retired, he or she is disqualified

from receiving temporary total disability indemnity benefits as a result of an injury received from the place of employment from which he or she retired, unless the application for benefits was received prior to his or her retirement. An individual who has retired is also barred from reopening for temporary total disability indemnity benefits an earlier claim filed in connection with an injury received at the place of employment from which he or she retired. This section does not preclude payments of benefits otherwise due a claimant if the retiree has returned to employment and suffers a compensable injury or payment of benefits if the compensable injury causes the individual to retire.

5.3. If a period of disability includes a reasonably ascertainable period of time during which the claimant would not have been performing work for any employer, then temporary total disability indemnity benefits shall not be paid during that period. This section does not apply to periods of time caused by a reduction in force, lay-off, or time-off provided in connection with an employee benefit.

§85-1-6. Special Rules for Permanent Partial Disability Claims.

[RESERVED]

§85-1-7. Notice and Litigation.

7.1. In all workers' compensation claims, the parties shall be limited to: (1) the claimant or the claimant's dependants; (2) the employer; and (3), in claims involving funds created by article two-c, chapter twenty-three of the West Virginia Code, the Insurance Commissioner.

7.2. Upon the making of any decision, the responsible party shall send all parties a written notice of the decision, setting forth the decision and the basis thereof, and informing the claimant or claimant's dependants of the right to protest the decision by filing a protest with the Office of Judges within sixty (60) days of the receipt of the decision.

7.3. In claims in which there was insurance coverage on the date of injury or last exposure, the private carrier providing coverage has sole authority to act on behalf of the employer in the claim, including, but not limited to, the ability to make claims decisions, appoint counsel for defense of the claim and make determinations regarding litigation strategy. An insured employer generally may not independently protest a decision issued by its carrier. However, in order to place certain issues into litigation, the employer's right to protest a decision issued by its carrier exists in the following limited circumstances:

a. Decisions incorporating findings made by the Occupational Pneumoconiosis Board; and

b. Decisions entered pursuant to W. Va. Code §23-4-7a(c)(1).

In the circumstances set forth in subdivisions a. and b. of this subsection, the employer's protest shall be subject to the carrier's sole authority to act on the employer's behalf in the litigation of the claim.

§85-1-8. Special Rules for Permanent Total Disability Claims.

[RESERVED]

§85-1-9. Special Rules for Non-Awarded Partial Benefits.

9.1. Non-awarded partial disability benefits pursuant to W. Va. Code §23-4-7a are payable only if the preponderance of the evidence indicates that a permanent impairment exists.

9.2. Non-awarded partial disability benefits are not payable in a claim that has been re-opened only for temporary total disability benefits if a permanent partial disability award was previously made in the claim.

9.3. Non-awarded partial disability benefits paid prior to entry of the permanent disability award are to be deducted from the permanent partial disability award when it is granted. If the non-awarded partial disability benefits exceed the amount of the award, the claimant is not entitled to any further benefits from the award. The excess is considered to be an overpayment and may be collected by the responsible party pursuant to section 12. of this rule.

9.4. The responsible party may cease paying non-awarded partial disability benefits if the responsible party concludes that the amount of non-awarded partial disability benefits already paid will likely exceed the expected partial disability award and may, as soon as practicable thereafter, enter a permanent partial disability award based on the most current information available and the guidelines set forth in W. Va. Code St. R. §85-20-1 et seq., if applicable.

9.5. If the claimant begins to receive rehabilitation benefits, non-awarded partial disability benefits shall not be paid until the rehabilitation process is completed.

9.6. Non-awarded partial disability benefits shall be immediately suspended if the claimant fails, without good cause, to present for an examination or rating. If suspended with good cause, benefits can be reinstated, without back pay, once the claimant presents for the examination or rating.

9.7. Non-awarded partial disability benefits are paid at the same rate as the permanent partial disability rate.

§85-1-10. Time Standards.

10.1. Injury and occupational disease claims. -- The responsible party shall rule on claims based upon injuries and occupational diseases other than occupational pneumoconiosis that are properly executed and filed on prescribed forms with the responsible party within fifteen (15) working days from the receipt of all required information by the responsible party. The responsible party shall consider all information and proof properly submitted in connection with each claim. Whenever a claim has not been adequately or properly developed for consideration, the responsible party may require the production of additional evidence. The fifteen (15) working days to rule on the claim shall be tolled during this evidence gathering process.

10.2. Occupational Pneumoconiosis claims. -- The responsible party shall enter non-medical decisions in occupational pneumoconiosis claims within ninety (90) days from the date the responsible party receives properly executed, prescribed forms. The responsible party shall consider all information and proof properly submitted in connection with each claim. Whenever the responsible party is of the opinion that a claim has not been adequately or properly developed for consideration, it may require the production of additional evidence. The ninety (90) days shall be tolled for no more than thirty (30) additional days during this evidence gathering process.

10.3. Medical treatment, medications, appliances, devices and supplies. -- The responsible party shall act upon an injured worker's request for authorization of medical treatment, medications, appliances, devices and supplies within fifteen (15) working days from the date the request was received by the responsible party.

10.4. Medical evaluations.

a. The responsible party shall refer claimants to physicians for examinations and evaluations as required by W. Va. Code §23-4-7a within twenty (20) days of the end of the one hundred twenty (120) day period of temporary total disability: *Provided*, That if the period of expected temporary total disability exceeds one hundred twenty (120) days, the responsible party shall make the referral within twenty (20) days of the end of the expected period of disability.

b. Examinations and evaluations to be performed by the Occupational Pneumoconiosis Board shall be scheduled and notice of the scheduling shall be transmitted to the parties within sixty (60) days after issuance of a non-medical decision directing referral to the Board.

10.5. Permanent disability decisions.

a. The responsible party shall act on a permanent disability evaluation report received from a physician to whom the responsible party referred a claimant in a claim for injuries and occupational diseases other than occupational pneumoconiosis within thirty (30) working days of receipt by the responsible party of the report.

b. The responsible party shall make a referral of a claimant to a physician for examination and evaluation in response to a request by or on behalf of the claimant for consideration of a permanent disability award in a claim for injuries and occupational diseases other than occupational pneumoconiosis within thirty (30) working days from the date the request was received by the responsible party.

c. Permanent partial disability awards may be paid, at the discretion of the responsible party, either by lump sum or in installments consistent with applicable law. Payment of permanent partial awards shall commence within fifteen (15) working days of the decision granting the award.

d. Findings of the Occupational Pneumoconiosis Board shall be transmitted to the parties within thirty (30) working days after the date of examination by the Board.

10.6. Application for reopening.

Applications for reopening of claims for temporary or permanent disability benefits shall be ruled upon by the responsible party within thirty (30) days from the date of receipt of the application by the responsible party. The responsible party shall consider all information and proof properly submitted in connection with the application. Whenever a claim has not been adequately or properly developed for consideration, the responsible party may require the production of additional evidence. The thirty (30) days to rule on the claim shall be tolled during this evidence gathering process.

10.7. Orders.

A responsible party shall comply with all orders of the Office of Judges and the Board of Review and all mandates of the West Virginia Supreme Court of Appeals within thirty (30) days after the date of receipt, unless the responsible party is required to act sooner under the terms of the order or mandate or the order or mandate is subject to a lawfully ordered stay.

§85-1-11. Child Support and Spousal Support Orders.

11.1. W. Va. Code §23-4-18 allows child and/or spousal support payments to be withheld from a claimant's compensation and sent to the Bureau for Child Support Enforcement. The term "compensation" refers to temporary total disability benefits, temporary partial rehabilitation benefits, non-awarded partial benefits, permanent partial disability benefits and permanent total disability benefits only.

11.2. The amounts to be withheld by the responsible party from a claimant's compensation are the amounts which are set out in the withholding notice issued pursuant to the West Virginia Domestic Relations Act.

11.3. When an award of compensation is for permanent partial or non-awarded partial benefits, the responsible party shall withhold 100% of those benefits to collect payment of child and/or spousal support benefits.

11.4. When compensation is for temporary total, temporary partial, rehabilitation temporary total, permanent total, or dependent benefits, the responsible party may only withhold the amount or amounts specified on the withholding notice, subject to the limitations set out in Table 1a.

§85-1-12. Overpayments.

12.1. Overpayments include any monies received from, or paid on a claimant's behalf by, the responsible party to which it is subsequently determined by the responsible party that the injured worker was not entitled. Overpayment may include, but shall not be limited to, the payment of temporary total disability benefits, permanent partial disability benefits, permanent total disability benefits, non-awarded partial disability benefits, temporary total rehabilitation benefits, temporary partial rehabilitation benefits, dependents benefits, fatal (104 week) benefits, travel reimbursement,

and medical benefits.

12.2. The responsible party may collect overpayments to claimants by withholding future disability benefits payable to the claimant or the worker's dependents in the same claim or other claims which are pending with the same responsible party to whom the overpayment is due. The overpayment specifically can be withheld from temporary total disability benefits, permanent partial disability benefits, permanent total disability benefits, non-awarded partial disability benefits, temporary total rehabilitation benefits, temporary partial rehabilitation benefits, and travel reimbursement.

12.3. Collection of overpayments from temporary total disability benefits, permanent total disability benefits, temporary total rehabilitation benefits and temporary partial rehabilitation benefits is limited to thirty percent (30%) of the periodic benefit amount (i.e. weekly, bi-weekly, monthly, etc.): *Provided*, That if the overpayment was based upon fraud, abuse or mistake, caused in whole or in part, by the claimant or his or her agent, then the amount of the overpayment may be recovered in full by withholding 100% of the periodic benefit amount until the overpayment is recaptured.

12.4. Collection of overpayments from travel reimbursement, permanent partial disability benefits and non-awarded partial disability benefits are not limited and may be withheld in full until the overpayment is satisfied.

§85-1-13. Occupational Pneumoconiosis and Occupational Disease Claims.

13.1. In any claim involving an occupational disease, other than occupational pneumoconiosis, resulting from inhalation of minute particles of dust over a period of time in the course of and resulting from employment: (1) which is filed as an occupational disease claim (as opposed to being filed as an occupational pneumoconiosis claim); and (2) in which a permanent disability determination is required, the claim shall be referred by the responsible party to the Occupational Pneumoconiosis Board for a determination of whole body medical impairment: *Provided*, That this subsection in no event affects the applicability of benefits or any other procedures available under the West Virginia Code for occupational disease claims other than occupational pneumoconiosis claims. In the claims described in this subsection, the Occupational Pneumoconiosis Board's findings and conclusions regarding whole body medical impairment have the same legal force and effect as any other findings and conclusions issued by the Board: *Provided*, That in such claims, the jurisdiction of the Occupational Pneumoconiosis Board is limited solely to the determination of whole body medical impairment.

13.2. Carpal tunnel and all other nerve entrapment syndromes of the upper extremity shall be filed as occupational disease claims unless the syndrome is a secondary diagnosis to an otherwise compensable injury.

13.3. The responsible party shall deny an occupational disease claim based on the opinion of a psychologist shall be denied. Psychologists are not treating physicians and are not permitted to certify occupational disease disability.

§85-1-14. Procedures for Suspension for Claimant Abuse.

14.1. When evidence is obtained justifying a finding that a claimant has engaged or is engaging in abuse, including, but not limited to, engaging in physical activities inconsistent with his or her compensable workers' compensation injury, or when evidence is obtained establishing a failure to undergo examinations or needed treatment, the responsible party will suspend the claimant's temporary total disability benefits.

14.2. Abuse may also include working at an unreported job while drawing temporary total disability benefits, making false or misleading statements to the responsible party or a health care provider for the purpose of securing any benefit, and altering, falsifying, destroying, or concealing workers' compensation related records.

14.3. Any claimant found to be engaging in abuse or who fails to undergo examinations or needed treatment shall receive a notice of benefit suspension. This notice is not protestable. The claimant has thirty (30) days to submit evidence justifying the reinstatement of benefits. If justification is not established, then the claimant will receive notice that the claim has been closed for temporary total disability payments. This notice is protestable. If justification is established, benefits will be reinstated with back benefits awarded.

14.4. In claims pending prior to approval of a managed health care plan, the claimant's failure to select a treating physician from an approved managed health care plan within sixty (60) days of notification to do so will result in a suspension of medical and indemnity benefits until the claimant's selection is made, unless the claimant is eligible to opt out of the managed care plan network.

§85-1-15. Travel Expenses-Medical Examination and Treatment.

15.1. General.

Claimants are entitled to reasonable travel, meals and lodging expenses actually incurred in connection with an authorized medical examination or treatment. In determining the reasonableness of such expenses, the responsible party shall utilize the travel regulations for State employees as a guide, unless specific provisions to the contrary are otherwise contained herein. A claimant may be reimbursed for mileage in connection with medical examination or treatment at a rate of 15 cents ($0.15) per mile. This rate does not apply to mileage reimbursement requests involving treatment provided when the responsible party requires the claimant to undergo the medical examination and has selected the physician, or when an employer is required to reimburse reasonable travel and other expenses, as provided for in the W. Va. Code §23-4-8. The rate provided for in the travel regulations for State employees shall apply to these latter reimbursement requests.

15.2. Physical limitations.

Where a medical vendor certifies that a claimant, because of the state of his or her health, requires special travel arrangements in order to report for an authorized examination, the claimant shall be reimbursed for the cost of such arrangements.

15.3. Claimant's residence.

The responsible party shall arrange for examination as near as practicable to the claimant's residence. If the claimant changes his residence after his or her date of injury to a location outside of West Virginia or to a location substantially further from the state than the residence on the date of injury, the following limitations shall be observed:

a. Where the change of residence is necessitated by reason of health or financial hardship, as determined by the responsible party upon a proper showing of such reasons, the responsible party shall, in writing, endorse the change of residence and direct payment of meal and lodging expenses in the following manner:

1. Where the distance between the residence and the situs of the examination is less than four hundred (400) miles, meal and lodging expenses are payable as provided in subsections 15.1. and 15.2. of this section;

2. Where the distance between the residence and the situs of the examination is greater than four hundred (400) miles, expenses actually incurred en route shall be payable, up to the cost of round trip air fare, economy class, between the closest airports offering scheduled commercial passenger service, as of the date the examination was scheduled;

3. Where the claimant objects to any decision or finding, and the employer does not object thereto, and the claimant is subsequently directed to report for examination upon request of the employer, the claimant is entitled to reimbursement of expenses from point of entry into West Virginia;

b. Where the claimant's change of residence is not necessitated by reason of health or financial hardship, expenses are payable only from point of entry into West Virginia.

§85-1-16. Complaints.

Upon receiving any inquiry from the Insurance Commissioner regarding a complaint filed with the Commissioner, a private carrier or self-insured employer shall, within fifteen (15) working days of the date appearing on the inquiry, furnish the Commissioner with a complete written response. A "complete written response" addresses all issues raised by the complainant or the Commissioner and includes copies of any documentation requested. This subsection is not intended to permit delay in responding to inquiries by the Commissioner or the Commissioner's staff in conjunction with a scheduled examination.

§85-1-17. Expert Witness Appearances.

17.1. An authorized treating physician, or an authorized consulting physician acting upon referral from an authorized treating physician, appearing at a hearing to give testimony regarding an examination of a claimant will be paid a fee by the responsible party commensurate with the service rendered for such appearance and testimony, not to exceed $100 per quarter hour.

17.2. All other expert witness appearance fees, including, but not limited to, any physician other than those physicians mentioned in subsection 17.1. of this section, medical vendors, rehabilitation providers, physical therapists or vocational specialists, shall be paid for by the party wishing to examine or cross-examine the expert witness at an amount agreed to by the parties based upon usual and customary rate for the profession involved, not to exceed $100 per quarter hour. If the expert witness demands an amount in excess of $100 per quarter hour to appear, it is the sole responsibility of the party who has retained the services of the expert or submitted a report or records of the expert as evidence in the case to pay for the difference.

§85-1-18. Implementation and Stay of Orders from the Office of Judges.

18.1. The responsible party may move for stay of any order entered by the Office of Judges for the payment of indemnity benefits, or which will necessarily require or result in the payment of such benefits, including, but not limited to, an order which finds a claim to be compensable, by filing a motion with either the Administrative Law Judge who entered the order or with the Board of Review.

18.2. A motion as described in subsection 18.1. of this section filed with the Office of Judges must be filed within ten (10) days of the date of entry of such order. A motion as described in subsection 18.1. of this section filed with the Board of Review must be filed contemporaneously with the notice for appeal. Any motion that is not timely filed in accordance with this subsection shall be dismissed with prejudice. In either case, the claimant may file a response to the motion within ten (10) days of the date on which the motion was filed, and the Office of Judges or Board of Review, whichever is applicable, shall enter an order granting or denying the motion within the ten (10) days from the end of the response period.

18.3. Any motion as described in subsection 18.1. of this section must include the following minimum content: (1) A statement of the reasons the stay is being sought; and (2) a statement of the grounds for the underlying appeal. Failure to include the minimum content described in this section is grounds for summary denial of the motion.

18.4. Any order granting a motion described in subsection 18.1. of this section shall expressly limit the stay to temporary total or permanent partial indemnity benefits to be paid in the claim as a result of the underlying Office of Judges order. No order granting a motion as described in subsection 18.1. of this section shall stay any medical, rehabilitation or permanent total disability benefits.

18.5. Any order granting a motion described in subsection 18.1. of this section by the Office of Judges shall expressly limit the duration of the stay to the expiration of the jurisdictional time limit for the filing of an appeal of the underlying order, or to the entry of a decision by the Board of Review if an appeal is filed. Any order granting a motion described in subsection 18.1. of this section by the Board of Review shall expressly limit the duration of the stay to the entry of a decision by the Board of Review of the underlying appeal: *Provided,* That if the Board of Review enters a decision remanding a case to the Office of Judges for further proceedings, any stay granted by the Office of Judges or Board of Review shall remain in effect until the Office of Judges enters a

new order on the issue which was remanded, at which time the stay will be lifted.

§85-1-19. Miscellaneous Administrative Matters.

If mail sent by the responsible party to a claimant, an employer, a vendor or any other party to a claim is returned due to an incorrect address, a reasonable effort will be made to determine the correct address. If after reasonable effort and due diligence a correct address cannot be located, the responsible party shall cease mailing correspondence to the party until such time as a correct address is provided.

§85-1-20. Preferred Drug List.

In accordance with the provisions of the Workers' Compensation Act [23-4-3(a)(3)] that require pharmacists filling a prescription for medication for a workers' compensation claimant to dispense a generic brand of the prescribed medication if the generic brand exists, the responsible party may establish a Preferred Drug List (PDL) for the purposes of:

a. Improving the quality of care of claimants by utilizing a PDL of generics and brand medications in the absence of generics;

b. Affecting cost savings in the provision of health care services by determining what is reasonably required; and

c. Optimizing pharmaceutical care and cost effectiveness.

TABLE 1a

Family	**Arrears**	**Percentage**
Not supporting another family	Less than 12 weeks old	Maximum of 50%
Not supporting another family	Greater than 12 weeks old	Maximum of 55%
Supporting another family, even just a spouse	Less than 12 weeks old	Maximum of 40%
Supporting another family, even just a spouse	Greater than 12 weeks old	Maximum of 45%